Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Evacuee Medical Intake and Assessment Form

Screening record #

Name

DOB: / / Gender: Male Female

Unaccompanied Minor: Y N N/A

City, State of Departure _____ Departure Date ____ / ____ / ____

City, State of Arrival _____ Arrival Date ____ / ____ / ____

City, State of Original Displacement _____ Displacement Date ____ / ____ / ____

Did you travel with family? Yes No

List names and ages:

_____

_____

_____

Interpreter Needed?

☐ Yes, specify language:_____

Do you have a cell phone or pager? ☐ No ☐ Yes If yes; what is the number (_____) _____ - _____

Are you affiliated with a tribe? ☐ No ☐ Yes, specify: _____

Are you a veteran or dependent of someone in active duty? ☐ No ☐ Yes, refer to VBA representative

Do you have a regular doctor? ☐ No ☐ Yes: Name_____, number (_____) _____ - _____

Do you have someone that you would like us to contact to give or receive critical health information?

☐ No ☐ Yes If yes; list contact information below:

Contact Person's Name: _____

Telephone/Mobile Phone/Pager: (___) _____ - _____

Contact Person's City, State: _____, _____

Created: 9.9.2005

DISPOSITION

☐ EMS/Emergency department
☐ Temporary housing, medical follow-up needed (Condition, time frame):
_____
_____
_____
☐ Special needs housing: medical follow-up needed (Condition, time frame):
_____
_____
☐ Pharmacy: Refills/prescriptions needed
☐ Mental Health EVAL
☐ Chemical Dependency EVAL
☐ Optometry needs, specify: _____
☐ Special needs follow-up, specify: _____
_____
☐ TB EVAL
☐ Measles EVAL

☐ Other, specify: _____
_____

☐ **Airborne isolation precautions**
☐ **Contact precautions**
☐ **Enteric precautions**

Person completing form (PRINT & SIGN)

_____ (Please Print Name)

_____DATE: _____

Created: 9.9.2005

BP: _____ HR: _____ RR: _____ Temp: _____

Allergies to medications? ☐ No ☐ **Yes, specify:** _____
_____

Food allergies? ☐ No ☐ **Yes, specify:**_____

A. Were you injured during or after the hurricane? ☐ No ☐ **Yes IF YES:**
☐ Self-inflicted – Intentional (violence) ☐ Assault-related – Intentional (violence)
☐ Unintentional injury (accidents) ☐ Heat related injury
Describe injury: _____
How where you injured? _____
Do you have any wounds? ☐ No ☐ **Yes, describe**: _____
Tetanus immunization history: _____
When was your last tetanus shot? _____
Tetanus PEP needed ☐ No ☐ **Yes**
Verbal consent for tetanus shot and TIG (if indicated) given? ☐ No ☐ **Yes**
Tetanus shot administered? ☐ No ☐ **Yes, specify preparation, (eg, dT, Td, etc):** _____
By whom (print name) _____
Date, time_____ Lot number: _____

B. Do you have a cough? ☐ No ☐ **Yes IF YES**:
How long have you had a cough? _____ Onset of cough: ____/ ___/ __
Have you been coughing up anything? ☐ No ☐ **Yes**
Have you coughed up any blood in the past month? ☐ **No** ☐ **Yes**
Have you lost 10 pounds or more of weight since you had the cough? ☐ No ☐ **Yes**
Have you felt feverish, had chills or night sweats for more than one week? ☐ No ☐ **Yes**
Have you ever been told you have TB? ☐ No ☐ **Yes, specify date:** _____
Were you taking medicine for TB just before hurricane Katrina? ☐ No ☐ **Yes**
Have you been in contact with someone who has had a cough for more than 2 weeks or has TB?
☐ No ☐ Yes
Did you take any medicine for the cough? ☐ No ☐ Yes (List on medication page)

IS TB SUSPECTED? ☐ No ☐ **Yes: REFER FOR R/O ACTIVE TB EVAL**
USE AIRBORNE ISOLATION PRECAUTIONS

C. Have you had a fever or felt feverish in the past 24 hours? ☐ No ☐ **Yes IF YES:**
How long have you had a fever or felt feverish? _____ Onset of fever: __/__/____
What was the highest temperature? _____ ☐ Not measured
Have you been exposed to other sick people? ☐ No ☐ **Yes, specify:** _____
_____
Are you feeling sick in any other way besides fever? ☐ No ☐ **Yes, specify:** _____
_____

D. Have you had diarrhea in the past 24 hours? ☐ No ☐ **Yes IF YES:**
How long have you had diarrhea? _____ Onset of diarrhea: __/__/____
Is there any blood in the diarrhea? ☐ No ☐ **Yes**
Did you take any medicine for the diarrhea? ☐ No ☐ **Yes**

E. Have you vomited in the past 24 hours? ☐ No ☐ **Yes**

F. **Is the person jaundiced?** ☐ No ☐ **Yes**

G. Do you have a rash? ☐ No ☐ **Yes** **IF YES:**

How long have you had a rash? _____ Onset of rash: __/__/____

Did fever start before rash? ☐ No ☐ **Yes**

Do you have:

Cough: ☐ No ☐ **Yes**

Runny Nose: ☐ No ☐ **Yes**

Red or Watery Eyes: ☐ No ☐ **Yes**

Where on your body did it start? _____

What did the rash look like? _____

Where did the rash spread (List body locations in order of spread)? _____

_____

On what part of your body was the rash mostly located? _____

Did the rash itch? ☐ No ☐ Yes

Have you been vaccinated against measles? ☐ No ☐ **Yes**

If yes, number of times vaccinated and dates: _____

IS MEASLES SUSPECTED? ☐ No ☐ **Yes: REFER FOR MEASLES EVAL**

USE AIRBORNE ISOLATION PRECAUTIONS:

H. Neurologic Illness **(Medical Evaluator: Please check if applicable)**

☐ Suspected meningitis / encephalitis, (fever, mental status change, focal neurologic deficits)

☐ Other, please specify: _____

Notes: _____

I. Have you had to drink any contaminated or dirty water?

☐ No ☐ **Yes, enter dates consumed**: _____ ☐Unknown

J. Have you been exposed to sewage?

☐ No, go to next question ☐ **Yes, enter dates exposed: _____** ☐Unknown

K. Do you take (or are your supposed to take) any medicine including aspirin or other drugs?

Include medicines for new problems since the hurricane.

☐ No ☐ **Yes: list all medications in the on the medications table on the last page.**

L. Do you need to speak to someone about extreme amounts of stress or emotional issues right now?

☐ No ☐ **Yes, refer to on-site mental health professional**

Do you currently take any medicines for mental or emotional problems? ☐ No ☐ Yes:

Have you ever taken any medicines for mental or emotional problems? ☐ No ☐ Yes:

If yes to either answer; please list medications, dosages and reasons for taking them on the medications list at the end of this assessment form.

M. Do you use alcohol, opiates, or medicines like Valium, Xanax, or Klonopin everyday?

☐ No ☐ **Yes, refer to on-site chemical dependency professional**

Notes:

Medical Evaluator: Please compete if Applicable:

☐ Mental Health Condition:

- ☐ Anxiety / Depression / Insomnia
- ☐ Disorientation / Confusion
- ☐ Acute psychosis / Suicidal or Homicidal
- ☐ Other, please specify: _____

Safety risk: ☐ No ☐ **Yes, specify:**

_____

N. Do you normally use a wheelchair, walker or crutches? ☐ No ☐ **Yes: list patient needs:** _____

_____

_____

O. Do you think you could be pregnant today? ☐ No ☐ **Yes: # weeks ____, # months____**

☐ Unknown If unknown, date of last menstrual period: ____ / ____ / ____

Any pregnancy-related problems requiring medical attention? ☐ No ☐ Yes

Notes:

P. Do you need glasses or contact lenses that you don't have? ☐ No ☐ **Yes**

Chronic medical problems

Q. Do you have any of the following chronic medical conditions?

☐ Cardiac disease

- ☐ Hypertension
- ☐ CHF
- ☐ Other, please specify: _____

☐ Pulmonary disease

- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Asthma
- ☐ Other, please specify: _____

☐ Kidney disease

- ☐ Dialysis dependent
- ☐ Other, please specify: _____

☐ Diabetes

- ☐ Insulin
- ☐ Oral Medication

☐ Immunocompromised condition (cancer, chemotherapy, high-dose or steroid use > 2 weeks, HIV/AIDS)

☐ Hereditary blood disorder

- ☐ Sickle cell disease
- ☐ Other, please specify: _____
- ☐ Requires blood products

☐ Other, please specify: _____
☐ Other, please specify: _____
☐ Other, please specify: _____

R. **Medical Evaluator: Please complete this section for persons with disabilities**

☐ Physical disability: ☐ No ☐ **Yes**
- ☐ Mobility impairment (Wheelchair, Walker, etc)
- ☐ Other, please specify: _____

☐ Sensory disability
- ☐ Visually impaired (blindness, limited vision)
- ☐ Hearing impaired
- ☐ Other, please specify: _____

☐ Cognitive disability
- ☐ Developmental delay
- ☐ Autism
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Other, please specify: _____

☐ Resided in a group home, nursing home, or assisted care facility.

Medications List (LIST ALL MEDICAIONS PATIENT IS SUPPOSED TO BE/IS TAKING)

Name of Drug	Reason for medication	Dose	Frequency	Has medication?	Number of days supply remaining	Requires medication immediately?	Needs a refill?	Requires prescription?
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No
				Yes / No		Yes / No	Yes / No	Yes / No

Created: 9.9.2005